actually made by Medicaid during that same time period. The calculation may then be used to make payments for the current year to hospitals eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. No payments under the Medicaid upper payment limit are being made to State government-owned or operated facilities. Up to the difference between Medicaid payments and 100 percent of what would have been paid under Medicare payment principles may be paid to privately owned and operated facilities, in accordance with applicable state and federal laws and regulations, including any provision specified in appropriations by the Florida Legislature. Up to the difference between Medicaid payments and 100 percent of what would have been paid under Medicare payment principles may be paid to non-State government-owned or operated facilities in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Florida Legislature.

VI. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the Florida Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Florida Title XIX Inpatient Hospital Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services that are comparable to those available to the general public.

VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations.

IX. Payment in Full

Participation in the Medicaid Program shall be limited to hospitals that accept, as payment in full for covered services, the amount paid in accordance with the Florida Title XIX Inpatient Hospital Reimbursement Plan.

X. Definitions

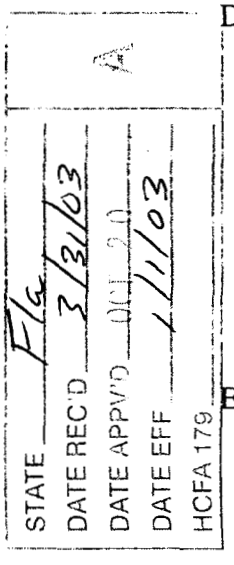
A. Actual audited data or actual audited experience - Data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008, F.A.C. (10/94) by the agency or representatives under contract with the agency.

B. Adjusted patient days - The sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

C. AHCA - Agency for Health Care Administration, also known as the Agency.

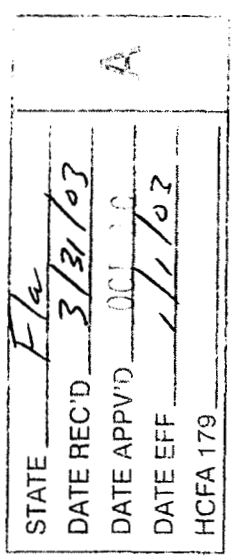
D. Allowable costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with Generally Accepted Accounting Principles (GAAP), except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C., except as further modified by the Florida Title XIX Inpatient Hospital Reimbursement Plan.

E. Base Medicaid per diem - Means the hospital's Medicaid per diem rate, initially established by the Agency for Health Care Administration on January 1, prior to



the beginning of each state fiscal year. For fiscal year 1993-1994, the base Medicaid per diem shall be the initial Medicaid per diem rate established on January 1, 1992. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution.

F. Charity care or uncompensated charity care - That portion of hospital charges reported to the Agency for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity. Each hospital will determine which patients are charity care patients by a verifiable process subject to the above provisions. In addition, each hospital must provide appropriate documentation of amounts reported as charity care.



For all patients claimed as charity care, appropriate documentation shall include one of the following forms:

1). W-2 withholding forms.

2). Paycheck stubs.

3). Income tax returns.

4). Forms approving or denying unemployment compensation or workers' compensation.

5). Written verification of wages from employer.

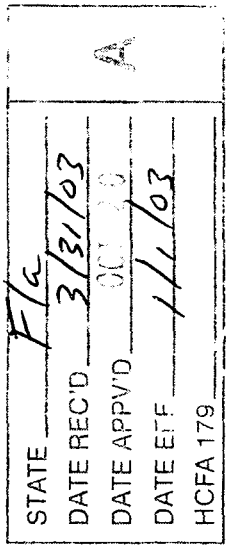
6). Written verification from public welfare agencies or any governmental agency which can attest to the patient's income status for the past twelve (12) months.

7). A witnessed statement signed by the patient or responsible party, as provided for in Public Law 70-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within 48 hours of the patient's admission to the hospital, as required by the Hill-Burton Act. The statement shall include an acknowledgment that, in accordance with Section 817.50, Florida Statutes, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second (2nd) degree.

8). A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

Charges applicable to Hill-Burton and contractual adjustments should not be claimed as charity care.

G. Charity care days - The sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.



H. Community Hospital Education Program (CHEP) hospitals – Hospitals that participate in a program established by the Community Hospital Education Act (381.0403, F.S.) and administered by the Department of Health. CHEP hospitals offer continuing medical education programs for interns and residents established on a statewide basis. The CHEP program provides financial support for interns and residents based on policies recommended and approved by the Community Hospital Education Council and the Department of Health.

I. Concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is also an inpatient in the same hospital at the same time.

J. Cost reporting year - A 12-month period of operations based upon the provider's accounting year.

K. Depreciation - Fixed costs related to buildings, fixtures, and movable equipment as apportioned to Medicaid by cost finding methods used in the CMS 2552 cost report.

L. Disproportionate share percentage - A rate of increase in the Medicaid per diem rate as calculated under this plan.

M. DOH – Florida Department of Health.

N. Eligible Medicaid recipient - An individual who meets certain eligibility criteria for the Title XIX Medical Assistance Program as established by the State of Florida.

O. Florida Medicaid log - A schedule to be maintained by a hospital listing each Medicaid patient's recipient number, dates of admission and discharge, and the charges and payments for services and goods received from the hospital's revenue centers

P. Florida Price Level Index - A spatial index that measures the differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of food, housing, apparel, transportation, and health, recreation and personal services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. For example, an index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the state average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.

Q. General hospital - A hospital in this state which is not classified as a specialized hospital.

R. HHS - Department of Health and Human Services

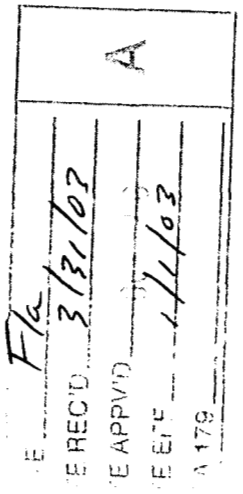
S. CMS PUB. 15-1 - Health Insurance Manual No. 15, herein incorporated by reference, also known as the Provider Reimbursement Manual available from the The Centers for Medicare and Medicaid Services.

T. Hospital - means a health care institution licensed as a hospital pursuant to Chapter 395, but does not include ambulatory surgical centers.

U. Inpatient general routine operating costs - Costs incurred for the provision of general routine services including the regular room, dietary and nursing services, and minor medical and surgical supplies.

V. Inpatient hospital services - Services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other recognized member of the medical staff and are furnished in an institution that:

1. Is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;
2. Is licensed as a hospital by AHCA;
3. Meets the requirements for participation in Medicare; and
4. Has in effect a utilization review plan, approved by the PRO pursuant to 42 CFR 456.100 (1998), applicable to all Medicaid patients.



W. Medicaid allowable variable costs - Allowable operating costs less depreciation as apportioned to Medicaid by cost-finding methods in the CMS 2552 cost report.

X. Medicaid days - The number of actual days attributable to Medicaid patients as determined by the Agency for Health Care Administration.

Y. Medicaid inpatient charges - Usual and customary charges made for inpatient services rendered to Medicaid patients. These charges shall be the allowable

charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

Z. Medicaid covered nursery days - Days of nursery care for a Medicaid eligible infant.

AA. Medicaid depreciation - Depreciation times the ratio of Medicaid charges to total charges divided by Medicaid inpatient days.

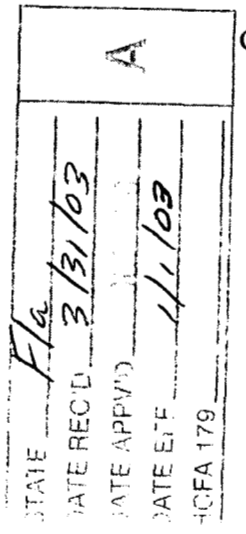
BB. Non-concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is not an inpatient in the same hospital at the same time.

CC. Non-covered services - Those goods and services which are not medically necessary for the care and treatment of inpatients as defined in CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.

DD. Patient's physician - The physician of record responsible for the care of the patient in the hospital.

EE. PRO - Utilization and quality control peer review organization.

FF. Rate semester - January 1 through June 30, of a given year or July 1 through December 31, of a given year.

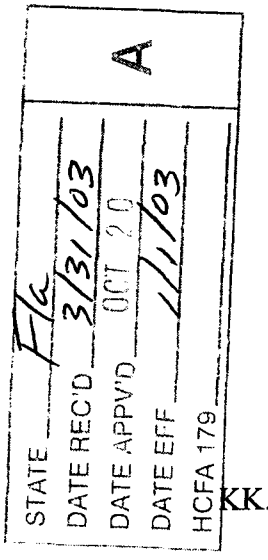


GG. Reasonable cost - The reimbursable portion of all allowable costs. Implicit in the meaning of reasonable cost is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs will not be included under the program. The determination of reasonable cost is made on a specific item of cost basis as well as a per diem of overall cost basis.

HH. Reimbursement ceiling - The upper limit for Medicaid variable cost per diem reimbursement for an individual hospital.

II. Reimbursement ceiling period - January 1 through June 30 of a given year or July 1 through December 31, of a given year.

JJ. Rural hospital - An acute care hospital licensed under Florida Statutes, Chapter 395 with 100 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:



1. The sole provider within a county with a population density of no greater than 100 persons per square mile; or

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

KK. Specialized hospital - A licensed hospital primarily devoted to TB, psychiatric, pediatric, eye, or cardiac care and treatment; or a licensed hospital that has ten or more residency training programs.

LL. Teaching Hospital - Means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

MM. Title V - Maternal and Child Health and Crippled Children's Services as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

NN. Title XVIII - Health Insurance for the Aged and Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395xx).

OO. Title XIX - Grants to States for Medicaid Assistance programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

PP. Total inpatient charges - Total patient revenues assessed for all inpatient services.

QQ. UR Committee - Utilization review committee.

APPENDIX A TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN
ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

The technique to be utilized to adjust allowable Medicaid variable costs for inflation in the process of computing the reimbursement limits is detailed below. Assume the following DRI Quarterly Indices.

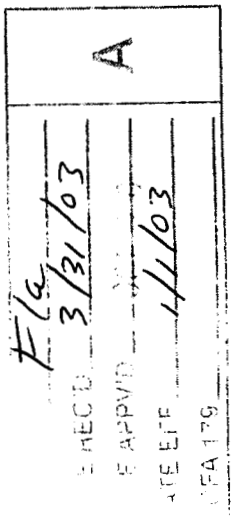
	1996	1997	1998	1999	2000
Q1	213.0	237.7	250.1	278.1	308.0
Q2	217.8	234.5	256.5	285.9	314.9
Q3	222.7	237.9	263.2	294.0	322.0
Q4	227.7	243.8	270.4	301.2	329.3

The elements in the above table represent a weighted composite index based on the following weights and the components:

COMPONENTS	WEIGHTS
Wages and Salaries	55.57
Employee Benefits	7.28%
All Other Products	3.82%
Utilities	3.41%
All Other	29.92%
	100.00%

Based on the quarterly indices, monthly indices are calculated by averaging pairs of quarterly indices and interpolating between these averages as follows:

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	213.0		
		215.4	March 31
2	217.8		
		220.3	June 30
3	222.7		
		225.2	Sept. 30
4	227.7		



April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)
= (220.3/215.4)$^{1/3}$ (215.4)
= 217.0

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ (March 31 Index)
= (220.3/215.4)$^{2/3}$ (215.4)
= 218.7

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given hospital for the first semester of 1999-2000 the index for September

30, 1999, the midpoint of the rate semester, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if a hospital has a fiscal year end of November 30, 1996then its midpoint is May 31, and the applicable inflation is:

September 1999 Index/May 1996 Index = 297.6/218.7 = 1.3607

Therefore, the hospital's reported variable cost Medicaid per diem is multiplied by 1.3607 to obtain the estimated average variable Medicaid per diem for the first rate semester of FY1999-2000. Similar calculations utilizing March 31 and the mid point yield adjustments for the second semester of FY1999-2000.

APPENDIX B TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Florida Medicaid Disproportionate Share Hospital (DSH) Appropriations

Regular DSH	$134,851,971	(Section V.D.)
Outlier Payments DSH (Regional Perinatal Intensive Care Center)	$7,455,159	(Section V.E)
Teaching Hospitals DSH	$20,888,999	(Section V.F.)
Mental Health DSH	$53, 362,198	(Section V.G.)
Rural DSH	$12,718,166	(Section V.H.)
Specialty DSH	$2,444.444	(Section V. I)
Primary Care DSH	$10,772,407	(Section V.J)
Children's DSH	$0	(Section V. K)

*These amounts are subject to change to comply with final federal DSH allotments.

STATE Fla	A
DATE REC'D 3/31/03	
DATE APPV'D OCT 20	
DATE EFF 1/1/03	
HCFA 179	